U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

DATE ISSUED: December 8, 2000

CASE NO.: 2000-BLA-473

In the Matter of

JOHNNY B. TURNER,
Claimant

v.

CLINCHFIELD COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Lawrence L. Moise, III, Esq.,
For the Claimant

Timothy W. Gresham, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a modification claim for benefits, under the Black Lung Benefits

Act, 30 U.S.C. § 901 *et seq.* ("Act"), filed on September 17, 1984.[1] The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

Claimant filed a prior claim for living miner's benefits on February 17, 1981. (DX 20-1). On July 2, 1981, benefits were denied by the district director because the evidence failed to establish claimant had pneumoconiosis and was totally disabled due to the disease. (DX 20-6).

The claimant filed his second claim for benefits on September 17, 1984. (DX 1). The claim was denied by the district director because the evidence failed to establish the elements of entitlement. (DX 13). On January 9, 1985, the claimant requested a hearing. (DX 14). On June 20, 1985, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX 21). On June 9, 1987, Administrative Law Judge Joel Harmatz issued a Decision and Order Denying Benefits, finding claimant did not suffer from pneumoconiosis. (DX 31). Claimant appealed the decision to the BRB and the BRB issued a Decision and Order dated August 31, 1990, affirming Judge Harmatz's denial of benefits. (DX 43). On June 28, 1991, the U.S. Court of Appeals for the Fourth Circuit granted employer's motion to dismiss claimant's appeal because claimant failed to file a timely appeal. (DX 50).

By letter dated August 15, 1991, claimant submitted additional medical evidence and requested a modification. (DX 51). On February 7, 1992, the claims examiner denied claimant's request for modification. (DX 62). By letter dated February 18, 1992, claimant requested a formal hearing. (DX 64). The district director issued a memorandum of the informal conference, dated May 28, 1992, denying the claim for benefits. (DX 72). On June 3, 1992, claimant request a formal hearing. (DX 76). The case was referred to the Office of Administrative Law Judges on September 2, 1992. (DX

[1] The following abbreviations are used for reference within this opinion: DX-Director's Exhibits; CX- Claimant's Exhibit; EX- Employer's Exhibit; TR- Hearing Transcript; Dep.- Deposition.

80). On December 29, 1993, Judge Joel Williams issued a Decision and Order Awarding Benefits, finding the evidence demonstrated a material change in conditions and claimant was totally disabled. (DX 95). The employer requested a reconsideration on January 20, 1994. (DX 96). On February 22, 1994, Judge Williams issued a Decision and Order on Reconsideration Awarding Benefits. (DX 102). The employer appealed to the BRB and on January 31, 1996, the BRB issued a Decision and Order remanding the case and vacating Judge Williams' finding that claimant established a material change in conditions. (DX 116). On September 30, 1996, Judge Daniel Stewart issued a Decision and Order on Remand Denying Benefits, finding the new evidence failed to establish a change in conditions and that claimant failed to prove the existence of pneumoconiosis. (DX 119). Claimant appealed to the BRB and on October 28, 1997, the BRB issued a Decision and Order remanding the case for further consideration. (DX 127). On April 21, 1998, Judge Stewart issued a Decision and Order on Remand Denying Benefits. (DX 133). Claimant appealed to the BRB and the BRB affirmed Judge Stewart's denial of benefits on September 10, 1999. (DX 142).

On November 4, 1999, claimant requested a modification. (DX 143). On January 24, 2000, the district director issued a Proposed Decision and Order denying claimant's request for modification. (DX 145). By letter dated February 9, 2000, claimant requested a formal hearing. (DX 146). The case was referred to the Office of Administrative Law Judges for a formal hearing on February 14, 2000. (DX 150). I was assigned the case on April 12, 2000.

On August 18, 2000, I held a hearing in Abingdon, Virginia, at which the claimant and employer were represented by counsel.[2] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-3, Director's exhibits ("DX") 1-150, and Employer's exhibits ("EX") 1-30 were admitted into the record. Post-hearing evidence consists of Employer Exhibit 31.

Post-hearing evidence consists of EX 31, a report from Dr. Hippensteel dated September 13, 2000. (TR 31).

Employer objected to the admission of DX 27 and DX 77, which both contain the deposition transcript of Dr. Sargent taken in 1987. I am reluctant to admit the deposition testimony in view of the Benefits Review Board's decisions dated October 28, 1997, September 10, 1999, and its August 31, 1990, affirming the administrative law judge's finding that claimant did not demonstrate good cause for his failure to comply with the twenty-day rule under 20 C.F.R. § 725.456(b). *See also, Turner v. Clinchfield Coal Co.*, BRB No. 87-2644 BLA (Aug. 31 1990). 20 C.F.R. § 725.456(b) allows the judge discretion to admit documentary evidence which

---

[2] Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court's jurisdiction.

is late. Also the Board, citing *Gillen v. Peabody Coal Co.*, 16 B.L.R. 1-22, 1-25 (1991), noted that the holding is the law of the case.[3] Therefore, I will not admit Dr. Sargent's deposition testimony.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the Miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a mistake of fact or material change in the claimant's condition?

VI. Whether Dr. Sargent's deposition testimony should be admitted into evidence?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least thirty-eight years.

[3] Furthermore, I also note that: "With respect to both res judicata and issue preclusion within the statutory and regulatory scheme of the black lung program, Congress specifically provided relief from the application of these doctrines only in two instances, both of them for the benefit of the claimant: in the filing of a request for modification, or in the filing of a duplicate claim . . . 20 C.F.R. § 725.309 and 725.310; *Lukman v. Director, OWCP*, 896 F.2d 1253 (10th Cir. 1990); *Dotson v. Director, OWCP*, 14 B.L.R. 1-10 (1990)(*en banc*)." The impact of these doctrines is that the claimant is foreclosed from relitigating any issue other than the four elements of entitlement.

B. Date of Filing[4]

The claimant filed his claim for benefits, under the Act, on September 17, 1984. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Clinchfield Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F, Part 25 of the Regulations.

D. Dependents[5]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife. (TR 33).

E. Personal, Employment and Smoking History

The claimant was born on February 18, 1927. (DX 3). He married Georgia Keith on June 11, 1948. (DX 5). He worked in the coal mines for thirty-eight years. The claimant last worked in the coal mines in 1984. (TR 33). Claimant testified that his breathing problems have worsened over the last seven years. (TR 34). Claimant last worked in the mines as a foreman. (TR 36). Claimant does not feel he is capable of performing his last coal mine job as a foreman because of his breathing problems. (TR 36). As a foreman, claimant had to walk and stoop and be on his knees. (TR 37-38).

II. Medical Evidence

I incorporate by reference the summary of evidence contained in Judge Daniel Stewart's Decision and Order on Remand Denying Benefits. (DX 133). The following is a summary of the evidence submitted since the prior denial.

---

[4] 20 C.F.R. §725.310 (For Modifications) provides:

> (a) . . .the director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

[5] See 20 C.F.R. §§ 725.204-725.211.

A. Chest X-rays

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
EX 15	09-16-91 05-08-00	Scott	B; BCR	2		Minimal discoid atelectasis right lower lung; left hemidiaphragm elevation; anterior wedging vertebral body.
EX14	09-16-91 05-09-00	Wheeler	B; BCR	2		Normal except probably healed fracture vertebra; minimal left lateral diaphragm elevation or eventration and small discoid atelectasis.
EX 24	09-16-91 06-08-00	Fino	B	1		Film completely negative.
EX 17	04-15-93 05-08-00	Scott	B; BCR	1		Minimal discoid atelectasis right lower lung; minimal left hemidiaphragm elevation; minimal anterior wedging of vertebral body.
EX 16	04-15-93 05-09-00	Wheeler	B; BCR	1		Normal except healed fracture vertebra; minimal left lateral diaphragm elevation or eventration and band of discoid atelectasis.
EX 25	04-15-93 06-08-00	Fino	B	1		Film completely negative.
CX 1	04-12-94 04-13-94	Mullens	BCR			Left ventricular cardiomegaly; plate like atelectasis right lung base; mild left hemidiaphragmatic elevation.
EX 2	04-12-94 02-03-00	Scott	B; BCR	1		Left hemidiaphragm elevation and minimal left CPA blunting, probably due to pleural fibrosis; discoid atelectasis right lower lung; no evidence of silicosis or CWP.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
EX 1	04-12-94 02-04-00	Wheeler	B; BCR	2		Normal except minimal left lateral diaphragm elevation with subtle pleural fibrosis blunting left CPA from healed inflammatory disease or surgery; focal arteriosclerosis aortic arch and minimal discoid atelectasis near right CPA.
EX 22	04-12-94 05-15-00	Hippensteel	B	3		Atelectasis right base; elevated left diaphragm with associated lateral plural thickening.
CX 1	04-25-95 05-02-95	Mullens	BCR			Generalized cardiomegaly; moderate left hemidiaphragmatic elevation; bilateral basilar plate-like atelectasis.
EX 19	04-25-95 05-08-00	Scott	B; BCR	2		Discoid atelectasis right lower lung; left hemidiaphragm elevation; minimal anterior wedging of vertebral body.
EX 18	04-25-95 05-09-00	Wheeler	B; BCR	2		Normal except few healed fractures mid T-spine; moderate left diaphragm eventration or elevation; small discoid atelectasis near right CPA and minimal obesity.
EX 26	04-25-95 06-08-00	Fino	B	1		Film completely negative.
DX 143; CX 1	04–09-97 04-09-97	Mullens	BCR			Borderline cardiomegaly; pulmonary hyperinflation with bilateral basalar parenchymal scarring and slight left hemi-diaphragmatic elevation.
EX 3	04-09-97 02-03-00	Scott	B; BCR	1		Left hemidiaphragm elevation and minimal left CPA blunting, probably due to pleural fibrosis; discoid atelectasis right lower lung; no evidence of silicosis or CWP.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
EX 4	04-09-97 02-04-00	Wheeler	B; BCR	2		Normal except minimal left lateral diaphragm elevation with subtle pleural fibrosis blunting left CPA from healed inflammatory disease or surgery; focal arteriosclerosis aortic arch and minimal discoid atelectasis right lower lung.[6]
EX 3	04-09-97 05-15-00	Hippensteel	B	3		Atelectasis right lung; elevated left diaphragm with associated lateral pleural thickening.
DX 143; CX 1	03-23-98 03-23-98	Robinette	B	1	1/0	q/q in four upper zones.
DX 143; CX1	03-23-98 03-23-98	Mullens	BCR			Chronic elevation of left hemidiaphargm and subsegmental atelectasis in right lung base.
EX 6	03-23-98 02-03-00	Scott	B; BCR	1		Left hemidiaphragm elevation; minimal discoid atelectasis right lower lung; no evidence of silicosis or CWP.
EX 5	03-23-98 02-04-00	Wheeler	B; BCR	1		Normal except minimal left lateral diaphragm elevation with subtle pleural fibrosis blunting left CPA from healed inflammatory disease or surgery; focal arteriosclerosis aortic arch, degenerative arthritis and minimal discoid atelectasis right lower lung; no evidence of silicosis or CWP.
EX 11	03-23-98 03-14-00	Fino	B	1		Film completely negative.
DX 143	09-21-99 09-21-99	Coburn	BCR			Elevation of left hemi-diaphragm with blunting of left costophrenic angle; bilateral lower lobe scarring; no acute infiltrate.

[6] Atelectasis is absence of air in a normally air-filled space or airlessness or collapse of a lung that had once been expanded. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 154 (28th Edition 1994).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
EX 12	09-21-99 03-14-00	Fino	B	1		Film completely negative.
EX 21	09-21-99 05-08-00	Scott	B; BCR	1		Minimal discoid atelectasis right lower lung; moderate left hemi-diaphragm elevation.
EX 20	09-21-99 05-09-00	Wheeler	B; BCR	1		No evidence of silicosis or CWP. Normal except minimal to moderate left lateral diaphragm elevation or eventration, small discoid atelectasis near right CPA; minimal tortuosity descending thoracic aorta.
EX 13	04-11-00 04-11-00	Hippensteel	B	1		Atelectasis in right base; elevated left diaphragm with mild plural thickening.
EX 27	04-11-00 06-08-00	Fino	B	1		Film completely negative.
EX 28	04-11-00 06-19-00	Wheeler	B; BCR	2		No evidence of silicosis or CWP; normal except minimal left diaphragm elevation with discoid atelectasis right lower lung; possible tiny linear scar near right heart border, ill defined discoid atelectasis near left hemidiaphragm and focal arteriosclerosis with minimal tortuosity descending thoracic aorta.
EX 29	04-11-00 06-19-00	Scott	B; BCR	1		Left hemidiaphragm elevation; discoid atelectasis right lower lung

* A- A-reader; B- B-reader; BCR- Board-certified radiologist; BCP-Board-certified pulmonologist; BCI= Board-certified internal medicine. Readers who are Board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))*(en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tracing**	**Comprehension Cooperation**	**Qualify**	**Dr.'s Impression**
Robinette 10-22-85 CX 1	58 74"	2.10 2.22+	33 42+	2.90 3.13	Yes		Yes Yes+	Moderate restrictive lung disease.
Robinette 07-10-91 CX 1	64 74"	1.70 1.89+	53	2.58 3.03+	Yes		Yes No+	Moderately severe obstructive lung disease with mild to moderate resting hypoxemia. Mixed obstructive and restrictive lung disorder.
Dahhan 10-17-91 CX 1	64 73"	1.54 1.68+	18.56 27.25+	2.75 2.78+	Yes		Yes Yes+	Severe airway obstruction with no reversibility after bronchodilator.
Robinette 03-28-96 CX 1	69 74"	1.37 1.45+		2.05 2.23+	Yes	Good Good	Yes Yes+	Mixed obstructive and restrictive lung disease with evidence of progression of his pulmonary disease as compared to 1991 study.
Robinette 04-09-97 DX 143; CX 1	70 74"	1.61 1.75+		2.84 3.04+	Yes		Yes No+	Mixed restrictive and obstructive lung disease, without response to bronchodilator; evidence of interval deterioration of lung function when compared to 1991 studies.

Physician **Date** **Exh.#**	**Age** Height	FEV_1	MVV	FVC	Tracing	Comprehension Cooperation	Qualify	Dr.'s Impression
Robinette 04-01-98 DX 143; CX 1	71 74"	1.37 1.38+		2.16 2.17+	Yes	Good Good	Yes Yes+	Very severe restrictive and obstructive lung disease; no response to bronchodilator; moderate impairment of diffusion capacity suggesting an active interstitial pulmonary process. When compared to 1991 studies, there is a marked deterioration, suggesting progressive restrictive lung disease.
Hippensteel 04-11-00 EX 13	73 73"	1.31 1.33+	25	1.90 2.05+	Yes		Yes Yes+	No improvement post bronchodilator.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

For a miner of the claimant's height of 74 inches, § 718.204(c)(1) requires an FEV_1 equal to or less than 2.19 for a male 71 years of age.[7] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.82 or an MVV equal to or less than 88; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Age	Height	FEV_1	FVC	MVV
58	74"	2.40	3.05	96

[7] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 74" here, the most often reported height.

64	74"	2.31	2.94	92
64	73"	2.24	2.86	90
69	74"	2.23	2.86	89
70	74"	2.21	2.84	88
71	74"	2.19	2.82	88
73	73"	2.13	2.74	85

C. Arterial Blood Gas Studies[8]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**pCO_2**	**pO_2**	**Qualify**	**Physician Impression**
10-22-85 CX 1	Johnston Hospital	39.0	62.8	No	
02-26-87 EX 7; CX 1	Johnston Hospital	39.9	73	No	
07-10-91 CX 1	Robinette	42.1 42.9+	68 72+	No No+	
10-17-91 CX 1	Dahhan	40.0 41.3+	68.6 74.5+	No No+	
02-07-92 CX 1	Johnston Hospital	46.6	66	No	

[8] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .
(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

Date Ex.#	Physician	pCO_2	pO_2	Qualify	Physician Impression
06-02-94 EX 8	Johnston Hospital	46.4	62.0	No	
04-25-95 EX 9; CX 1	Robinette	44.1	66.0	No	
03-28-96 EX 10; CX 1	Robinette	46.9	63.0	No	Hypercapnia and hypoxemia.
04-09-97 DX 143; CX 1	Robinette	43.3	67.0	No	
04-01-98 DX 143; CX 1	Robinette	47.9	65.0	No	
04-11-00 EX 13	Hippensteel	44.2 38.0+	66.5 83.3+	No No+	Mild hypoxemia at rest, normal oxygenation post-exercise.

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

D. Physicians' Reports and Office Notes

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(c)(1), (2), or (3), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Hippensteel

Dr. Hippensteel, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, examined claimant on May 18, 2000 and reviewed claimant's medical records. (EX 13). Dr. Hippensteel noted claimant worked in the mines for a total of thirty-eight years, with twenty-six years underground. Claimant last worked as a mine foreman, which required him to load coal and crawl, with occasional heavy labor. Claimant stopped working in October of 1984 due to his shortness

of breath. Claimant is taking breathing medications, occasionally uses oxygen, and sleeps in an elevated hospital bed. Upon examination, Dr. Hippensteel noted mild wheezes in the bases and a decrease in air movement bilaterally. Dr. Hippensteel found no evidence of CWP based on his x-ray interpretation of "0/0". Dr. Hippensteel noted a pulmonary function study showed severe restriction with no improvement post bronchodilator. Dr. Hippensteel opined that "it is possible that his suboptimal effort masked the determinability of some obstruction on these tests." Arterial blood gases at rest showed mild hypoxemia and his carboxyhemoglobin level is normal.

Dr. Hippensteel concluded that claimant's chest x-ray abnormalities are unrelated to pneumoconiosis that could cause some pulmonary function test abnormalities that have been chronic, dating back to April of 1994. Dr. Hippensteel found no radiographic evidence of CWP or any coal dust related disease of the lungs. Dr. Hippensteel noted that there is a suggestion, from claimant's normal lung volumes, that he does not have severe respiratory impairment and certainly does not have restrictive impairment. Based on a review of claimant's medical records, Dr. Hippensteel concluded that claimant does not have CWP. Dr. Hippensteel noted the x-ray evidence is strongly against CWP and that there has not been a progression of findings over time to suggest a deterioration in lung function. Dr. Hippensteel opined that claimant has significant obstructive pulmonary dysfunction that is aggravated by his obesity and decreased function of the left diaphragm. Dr. Hippensteel opined that none of the abnormalities are related to prior coal dust exposure. Dr. Hippensteel diagnosed artifactual reduction in lung volume secondary to obstructive disease. Dr. Hippensteel found that claimant does not suffer from emphysema. Dr. Hippensteel stated that there is a suggestion that the claimant has intrinsic airways disease beyond that caused by cigarette smoking, since he continued to have problems of progression of his obstructive disease after he stopped smoking. Dr. Hippensteel noted claimant had a significant smoking history that produced some variable obstruction with reversibility before he stopped smoking in 1984. Claimant's non coal-related lung disease is enough to keep him from working at his previous job in the mines and is aggravated by his impairment in diaphragmatic function and obesity. Dr. Hippensteel opined that the claimant's chronic respiratory infections appear to be the major cause of his current symptoms. The symptoms are not related to industrial bronchitis or prior coal dust exposure.

Dr. Hippensteel testified at deposition on July 17, 2000. (EX 30). Dr. Hippensteel reported claimant smoked one pack of cigarettes per day from age twelve until 1984, approximately a forty-five pack-year smoking history. (Dep. 7). Dr. Hippensteel reported claimant complained of shortness of breath, frequent respiratory infections, and chronic sinus congestion. (Dep. 8). Claimant had a history of chest pain which radiated down his left arm. (Dep. 9). Upon examination, Dr. Hippensteel noted mild wheezes, decrease in air movement, and irregular heart rhythm. (Dep. 10). Dr. Hippensteel interpreted an x-ray as "0/0" and found an elevated left diaphragm with mild pleural thickening and plate atelectasis. (Dep. 12). An elevated diaphragm can affect lung function tests because the patient is unable to take a full breath and it can cause rales or crackles. (Dep. 13).

Based on pulmonary function studies, Dr. Hippensteel could not completely rule out an

obstruction. (Dep. 20). Dr. Hippensteel opined that claimant's elevated diaphragm and compression of his left lower lung and atelectasis in the right base are causing claimant's lung not to participate in diffusion. (Dep. 21). Dr. Hippensteel opined that it is possible for a person with an elevated hemidiaphragm and plate atelectsis to show a restrictive impairment. (Dep. 22). Dr. Hippensteel opined that claimant's elevated hemidiaphragm is not related to coal dust exposure. (Dep. 24). Interpreting the pulmonary function study, Dr. Hippensteel opined that the severe restriction confirmed by the spirometry alone was not confirmed by the lung volumes and showed that there was a problem with how the claimant moved air in and out. (Dep. 27). Dr. Hippensteel agreed that the pulmonary function study was valid. (Dep. 28-29). Dr. Hippensteel opined that claimant's restrictive impairment is not based on intrinsic lung disease or CWP. (Dep. 29).

Dr. Hippensteel opined that claimant does not suffer from CWP or from any chronic lung disease related to coal dust exposure. (Dep. 24). Claimant has a respiratory impairment due to the decreased function of his left diaphragm and plate atelectasis. Claimant also suffered from episodes of bronchitis. Dr. Hippensteel opined that the combination of problems would keep claimant from his last coal mine employment. Dr. Hippensteel opined that claimant's respiratory disability is not related to exposure to coal dust. (Dep. 25).

Dr. Hippensteel submitted a supplemental report, based on a review of additional medical records, dated September 13, 2000. (EX 31). Dr. Hippensteel found the claimant had difficulty giving adequate effort for the pulmonary function tests. Claimant had episodes of recurrent bronchitis which Dr. Hippensteel opined was not related to industrial bronchitis. Dr. Hippensteel opined that claimant does not suffer from a permanent restriction. Dr. Hippensteel criticized Dr. Robinette's findings of pulmonary hypertension and stated Dr. Robinette was incorrect in finding a fixed impairment. Dr. Hippensteel found no evidence of cor pulmonale. Dr. Hippensteel opined that the evidence does not support diagnosis of cor pulmonale, pulmonary hypertension and restrictive lung disease.

Dr. Robinette

Dr. Robinette, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader, testified at deposition on June 20, 2000. (CX 3). Dr. Robinette has seen the claimant every six months since 1991. Dr. Robinette first treated claimant in 1985. (Dep. 4). Claimant complained of cough and shortness of breath on exertional activity. In 1985 and 1991, Dr. Robinette noted some emphysematous changes with evidence of mild pulmonary hypertension and dust reticulation, and the pulmonary function studies demonstrated evidence of airflow obstruction. The arterial blood gas studies demonstrated a decrease in arterial oxygenation. (Dep. 5). Dr. Robinette observed inspiratory crackles in both lung fields, wheezes, rhonchi and prolongation of the expiratory phase or difficulty expelling air out of the chest. (Dep. 8).

Dr. Robinette reported claimant worked for thirty-one years in coal mine employment as a maintenance foreman, repairman, loader operator and other jobs. Claimant last worked as a foremen which required him to crawl. (Dep. 9). Dr. Robinette treated claimant with bronchodilators, inhalers, oxygen and breathing medication. Dr. Robinette reported that claimant stopped smoking in 1985, and had a forty-pack year smoking history. (Dep. 10). Dr. Robinette opined that claimant's respiratory condition has worsened over time and has been static over the past two years. Claimant's arterial blood gases show evidence of hypercapnia, increased carbon dioxide and low oxygen levels. (Dep. 11).

Dr. Robinette opined that claimant has interstitial fibrosis compatible with coal dust exposure and pneumoconiosis; emphysema; and restrictive and obstructive ventilatory defect. Dr. Robinette concluded that claimant's condition is severe and claimant has been unable to work since 1991. (Dep. 12). Dr. Robinette reported claimant has lost lung function since 1985. Claimant experiences shortness of breath walking and performing any exertional task. Dr. Robinette concluded that coal dust caused his restrictive lung disease and part of his chronic airflow obstruction. Dr. Robinette opined that claimant's occupational lung disease has significantly contributed to his respiratory symptoms. (Dep. 13).

Dr. Robinette opined that claimant's smoking history would cause a decline in FEV1 and FVC, but smoking would not cause a reduction in total lung capacity and does not account for all the inspiratory crackles. (Dep. 13-14). Hypercapnia and hypoxemia can be associated with cigarette smoking and restrictive lung disease. Dr. Robinette is unable to separate how much damage was caused by cigarette smoking and how much was caused from coal dust exposure. (Dep. 14). Dr. Robinette opined that claimant is disabled due to his lung disease from working and is incapable of performing any manual labor. (Dep. 15-16). Dr. Robinette opined that claimant's emphysema could be caused from both cigarette smoking and coal dust reticulation. (Dep. 16). Dr. Robinette opined that coal dust accounts for some of claimant's oscillatory findings, crackles, restrictive lung disease, reduction in diffusion capacity, and emphysema.

(Dep. 16-17). Dr. Robinette concluded that coal dust exposure has contributed to claimant's respiratory impairment and all of claimant's lung disease cannot be solely attributed to cigarette smoking. (Dep. 17).

Dr. Robinette does not consider claimant to be obese. (Dep. 18). Dr. Robinette agreed that cigarette smoking can cause COPD and chronic bronchitis. Claimant has a mild elevation of his left hemidiaphragm. (Dep. 20). The elevated hemidiaphragm could affect lung function, but would not account for the progressive volume loss Dr. Robinette has noted over the years. (Dep. 21). Dr. Robinette agreed that claimant's x-ray abnormalities have not changed over the years. (Dep. 22). Dr. Robinette observed a reduction in claimant's total lung capacity. (Dep. 24). Dr. Robinette opined that claimant's recurrent infections are due to his lung disease. (Dep. 25). Claimant's lung function has

deteriorated since 1985 and claimant is not able to work based on his ventilatory capacity. (Dep. 26). Dr. Robinette opined that atelectasis normally have localized crackles and not diffuse crackles which Dr. Robinette observed in the claimant. (Dep. 27). Claimant's coal dust exposure and smoking ended at the same time. (Dep. 30). Dr. Robinette opined that fibrotic lung disorder due to coal dust exposure, interstitial fibrosis, caused claimant's restrictive impairment. (Dep. 31-32).

Claimant submitted Dr. Robinette's office notes. On March 21, 2000, Dr. Robinette noted that a past x-ray, dated September 21, 1999, demonstrated mild interstitial fibrosis with q/p opacities and profusion of "1/0". Pulmonary function studies demonstrated severe obstructive ventilatory defect. Upon examination, Dr. Robinette reported diminished breath sounds with bilateral inspiratory crackles and wheezes. (CX 1).

On September 21, 1999, Dr. Robinette noted marked dyspnea on minimal exertion with wheezing, cough, congestion, and respiratory tract infection. Upon examination, Dr. Robinette noted bilateral wheezes. On March 23, 1999, Dr. Robinette diagnosed chronic interstitial lung disease occurring as a consequence of his intrinsic coal dust exposure. Upon examination, Dr. Robinette reported diminished breath sounds with inspiratory crackles and a few wheezes in both lung fields. (DX 143).

On September 24, 1998, Dr. Robinette noted a pulmonary function study showed deterioration of FEV1 and FVC suggesting progressive restrictive lung disease. An x-ray, profusion "1/0", demonstrated early black lung. Upon examination, Dr. Robinette noted diminished breath sounds with inspiratory crackles present in both bases. Dr. Robinette concluded that claimant's condition is chronic, irreversible and directly related to his prior coal mining employment. On March 23, 1998, Dr. Robinette noted claimant was unable to walk more than a few feet without having to stop and rest. Claimant suffered from paroxysmal wheezing and shortness of breath. Dr. Robinette observed bilateral inspiratory crackles in both lung bases. (DX 143; CX 1).

On September 23, 1997, Dr. Robinette reported that claimant was dyspneic on exertional activity, suffered from a chronic cough and congestion. Dr. Robinette noted a chest x-ray demonstrated underlying black lung disease. Dr. Robinette observed diminished breath sounds with inspiratory crackles. Dr. Robinette diagnosed black lung disease, intercurrent hypoxemia, restrictive and obstructive lung disease. Dr. Robinette opined claimant's black lung disease is chronic and irreversible and his pulmonary disease is directly related to his coal mining employment. On March 24, 1997, Dr. Robinette reported that claimant suffered from a chronic cough, congestion, shortness of breath, and diminished breath sounds with inspiratory crackles. Antibiotics needed to suppress acute bronchitis. (DX 143; CX 1).

On September 24, 1996, Dr. Robinette reported claimant was dyspneic and had diminished breath sounds with poor air movement, bilateral inspiratory crackles in both lung fields with prolongation of the expiratory phase. Dr. Robinette noted claimant had no response to bronchodilator

after pulmonary function study. Arterial blood gases showed elevated PCO2 and decreased PO2. Dr. Robinette prescribed inhalers and antibiotics for acute bronchitis. Dr. Robinette opined that claimant is totally disabled from working based on his pulmonary disease alone. Claimant's pulmonary disease occurred as a consequence of his coal mine employment. On March 25, 1996, Dr. Robinette noted the pulmonary function studies demonstrated evidence of a mild obstructive ventilatory defect. Dr. Robinette opined claimant suffered from underlying chronic bronchitis, moderate obstructive and restrictive lung disease with chronic left hemidiaphragm elevation. Dr. Robinette reported that claimant was severely dyspneic on minimal exertional activity. Upon examination, Dr. Robinette noted diminished breath sounds with bilateral expiratory wheezes and inspiratory crackles in both lung bases and moderate prolongation of the expiratory phase. (CX 1).

On August 15, 1995, Dr. Robinette reported bilateral wheezes, diminished breath sounds, crackles in both bases. Claimant was dyspneic on minimal exertional activity and suffered episodes of bronchitis. On May 17, 1995, Dr. Robinette reported diminished breath sounds, inspiratory crackles in left base. (CX 1).

By letter dated April 27, 1995, Dr. Robinette stated he evaluated claimant in 1991 and diagnosed CWP; underlying chronic bronchitis; moderate obstructive and restrictive lung disease; hemidiaphragm elevation; discoid atelectasis in right lung base; mild fibro-emphysematous change; and evidence of mild pulmonary hypertension. Dr. Robinette reported claimant suffered from cough, congestion and dyspnea. Dr. Robinette observed bilateral inspiratory crackles, few wheezes, and few rhonchi. A chest x-ray revealed discoid atelectasis, chronic left hemidiaphragm elevation, chronic interstitial fibrosis consistent with occupational lung disease, and pulmonary emphysema. (CX 1).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. *20 C.F.R. §§ 718.202-718.205; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp*., 105 F.3d 166, 170 (4th Cir. 1997).

Under 20 C.F.R. § 725.310, a modification petition may be based upon a mistake of fact or a change in conditions. In determining whether a mistake of fact has occurred, the Administrative Law Judge is not limited to a consideration of newly submitted evidence. All evidence of record may be

reviewed to determine whether a mistake of fact was previously made. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256, 92 S.Ct. 405, 407, 30 L.Ed.2d 424 (1971)(per curiam)(decided under Longshore and Harbor Workers' Compensation Act). The Administrative Law Judge has "broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence previously submitted."[9] *O'Keefe*, 404 U.S. 254 at 257; *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*), *quoting Jessee v. Director, OWCP*, 5 F.3d 723, 724 (4th Cir. 1993). Therefore, a complete review of the record will be conducted to determine whether a mistake of fact exists. A review of the record shows that there has been a mistake of fact. The claimant has established that there has been a mistake of fact in the determination of claimant's smoking history in the prior decision.

To assess whether a change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and consider it in conjunction with the previously submitted evidence to determine if the weight of the evidence is sufficient to demonstrate an element or elements of entitlement which were previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994)("Change in conditions" not established where the existence of pneumoconiosis by chest x-ray was demonstrated in the original claim and the claimant merely submitted additional positive x-ray readings on modification); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *and, Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.*, 16 B.L.R. 1-71 (1992). After reviewing the newly submitted evidence in conjunction with the previously submitted evidence, I find claimant has established elements which were previously adjudicated against him in the prior decision. Therefore, as discussed more fully below, I find claimant has established a material change in conditions.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[10] 30 U.S.C. § 902(b) and 20 C.F.R. §718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.

---

[9] The United States Court of Appeals for the Fourth Circuit reiterated its well-established modification standard in *Consolidation Coal Co. v. Borda*, ___ F.3d ___, 21 B.L.R. _____, No. 98-1109 (4th Cir. March 15, 1999), holding that "a request for modification need not meet formal criteria," and "there is no need for a smoking-gun factual error, changed conditions, or startling new evidence." Id. at 4.

[10] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." " . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after Jan. 1, 1982, with no evidence of complicated pneumoconiosis.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999)(En banc). *See Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993) and *Mullins Coal Co. of Virginia v. Director,*

OWCP, 483 U.S. 135 (1987).

It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, in as much as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the earlier. . ." *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.[11] 20 C.F.R. § 718.202(a)(1). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority

of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31, 1-37 (1991).

The record contains 135 readings of 31 x-rays dated between March 15, 1971 and April 11, 2000. Of the 135 interpretations, only approximately eight were positive for pneumoconiosis. Analyzing the x-ray interpretations previously submitted, I find Judge Stewart did not make a mistake of fact in finding the x-rays negative for pneumoconiosis. Noting that twenty-six x-rays were taken over an extended period of time and crediting the most qualified physicians, Judge Stewart found the x-ray evidence insufficient to establish the existence of pneumoconiosis.

I also find the previous x-ray evidence insufficient to establish pneumoconiosis. Dr. Harrison, a

---

[11] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. . . *See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W. VA. LAW REVIEW 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

B-reader and Board-certified radiologist, interpreted the September 20, 1974 x-ray as positive. However, the record contains over fifty negative interpretations of subsequent x-rays by well-qualified physicians. Therefore, I do not afford Dr. Harrison's interpretation much weight.

Dr. Gaziano, a B-reader and Board-certified radiologist interpreted the October 1, 1984 x-ray as positive. Dr. Erymilaz, a Board-certified radiologist, interpreted the October 3, 1984 x-ray as positive. However, the record contains twenty-six negative interpretations by well-qualified physicians of subsequent x-rays between October 3, 1984 and August 13, 1985. Therefore, I do not credit Dr. Erymilaz and Dr. Gaziano's interpretations.

Dr. Bassham, a Board-certified radiologist, noted interstitial pulmonary fibrosis on the October 22, 1985 x-ray. However, four dually qualified physicians found the October 22, 1985 x-ray negative for pneumoconiosis. Therefore, I find the October 22, 1985 x-ray negative for pneumoconiosis. Likewise, Dr. DePonte, a B-reader and Board-certified radiologist found the November 4, 1985 x-ray positive for pneumoconiosis. However, four dually qualified physicians interpreted the November 4, 1985 x-ray as negative for pneumoconiosis. Furthermore, there were no positive interpretations of subsequent x-rays taken on July 10, 1991 and September 16, 1991.

Finally, Dr. Robinette interpreted the October 17, 1991 x-ray as positive and submitted a positive interpretation dated September 10, 1992. However, Drs. Fino, Spitz and Wiot, qualified as B-readers and/or Board-certified radiologist, found the October 17, 1991 x-ray negative. Furthermore, Drs. Byers, Scott, Wheeler and Fino found the April 15, 1993 x-ray negative for pneumoconiosis. Therefore, I find Judge Stewart did not make a mistake of fact in finding that the x-ray evidence failed to establish the existence of pneumoconiosis and I find the previous x-ray evidence insufficient to establish the existence of pneumoconiosis.

Analyzing the most recent chest x-ray evidence of record, I find claimant has not established a material change in conditions. There were twenty-five interpretations, by physicians qualified as B-readers and/or Board-certified radiologists, of x-rays taken between April 12, 1994 and April 11, 2000. The newly submitted evidence contains only one positive interpretation by Dr. Robinette of the March 23, 1998 x-ray. Twelve interpretations of x-rays dated March 23, 1998 through April 11, 2000, by physicians qualified as B-readers and/or Board-certified radiologists, were interpreted as negative for pneumoconiosis. Based on the majority of negative interpretations by well-qualified physicians of the most recent x-ray evidence of record, I find claimant has not established the existence of pneumoconiosis by x-ray evidence. Therefore, considering the previous x-ray evidence in conjunction with the newly submitted evidence and crediting the most recent evidence of record, I find claimant has not established a material change in conditions or a mistake of fact.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in §

718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[12] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983). Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

After reviewing all of the evidence of record, I find Judge Stewart made a mistake of fact in finding claimant had 63 pack-years smoking history. Judge Stewart used the 63 pack-years history to discredit Drs. Robinette, Smiddy, and Kanwals' opinions, finding the physicians did not consider the claimant's more extensive smoking history in their conclusions. Judge Stewart credited Dr. Dahhan's opinion over Dr. Robinette's opinion based on finding 63 pack-years smoking history in Dr. Dahhan's October 17, 1991 report. However, in Dr. Dahhan's October 21, 1991 report, he actually found claimant had "between 40 to 60 pack years" smoking history. (DX 54; CX 1). Furthermore, in his May 29, 1985 report, Dr. Dahhan reported a variable smoking history, from "at one time" a pack and a half of cigarettes daily, to one-half a pack daily for the last six months. In his May 1985 report, Dr. Dahhan found claimant smoked for 43 years, but did not determine the number of pack-years. Dr. Dahhan did not make a specific finding of 63 pack-years. Because Dr. Dahhan opined that claimant could have between a 40 and 60 pack-years smoking history, I will analyze the other evidence of record to determine the most accurate smoking history.

When examining all of the medical records, I find an approximate 40 pack-years smoking history more accurate. Judge Stewart made a mistake of fact in finding Dr. Dahhan's report was sufficient to establish a 63 pack-years smoking history. A majority of the medical reports indicate that

---

[12] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984). . ."

claimant quit smoking around 1985. A vast majority of the physicians' reports indicate approximately a 40 year smoking history. In June of 1984, Dr. Turner reported claimant smoked one pack of cigarettes per day for 36 years; Dr. Canaille reported claimant smoked one pack of cigarettes per day for 20 or more years; Dr. Byers reported claimant smoked one pack to a pack and a half per day for 25 to 30 years; Dr. Hippensteel reported 45 pack-years smoking history in July of 2000; and Dr. Robinette reported 40 pack-years smoking history consistently from 1985 through the time of his deposition in June of 2000.[13] I afford the most weight to Dr. Robinette's opinion because he treated claimant on a regular basis, every six months since 1991. Dr. Robinette consistently reported claimant had approximately 40 pack-years smoking history. Based on Dr. Robinette's findings and considering the entire record, I find claimant had approximately 40 pack-years smoking history.

I also find Judge Stewart's reasoning inconsistent. When weighing Dr. Robinette's opinion, Judge Stewart found it not well reasoned because Dr. Robinette reported 40 pack-years smoking history and "was unaware of claimant's more extensive history of cigarette smoking." (D&O at page 31; *see also* pages 29 and 33). The Judge Stewart found Dr. Byers' opinion well reasoned when Dr. Byers only reported a 25 to 45 pack-year smoking history. (D&O at 31). Furthermore, Judge Stewart credited Dr. Branscomb's opinion, when Dr. Branscomb did not address the extent of claimant's cigarette smoking history in his report. Because the majority of the evidence favors 40 pack-years smoking history and Judge Stewart used a mistaken smoking history to discredit several physicians' opinions, I will analyze the old medical reports in conjunction with the newly submitted reports to determine whether coal dust exposure contributed to claimant's pulmonary diseases.

In analyzing the medical records on the issue of whether coal dust exposure contributed to claimant's pulmonary problems, I find that Dr. Dahhan's opinion that coal workers' pneumoconiosis causes a restrictive pulmonary pattern is of concern. Dr. Dahhan stated that claimant's "respiratory disability is caused by obstructive lung disease that has resulted from smoking and not caused by pulmonary impairment arising from his coal mining work and coal dust exposure **since such impairment is manifested by restrictive lung disease that presents itself with restrictive pattern on pulmonary function studies**, alteration of the blood gas exchange mechanism at rest that worsens after exercise and pulmonary fibrosis on chest x-ray, none of these abnormalities are seen in Mr. Turner's case, leading me to conclude that his pulmonary disability is not caused or related to coal dust exposure or coal workers' pneumoconiosis." *(Emphasis added)*. (CX 1).[14]

---

[13] In the October 22, 1985 examination, Dr. Robinette reported claimant smoked one to one and a half packs of cigarettes daily, for 40 pack-years smoking history. Claimant reported he quit smoking four months prior to his examination.

[14] In a letter dated December 2, 19901, Dr. Robinette criticized Dr. Dahhan's opinion. Dr. Robinette stated that Dr. Dahhan's argument that obstructive abnormality disqualifies an individual from pneumoconiosis is invalid. Dr. Robinette opined that CWP is not only a restrictive lung disorder.

In *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 951 (4th Cir. 1997), the Court stated that "[A]n ALJ must not rely upon the opinion of an expert who expresses an opinion based on a premise 'antithetical to the Black Lung benefits Act' because such an opinion 'is not probative.'" *Thorn v. Itmann Coal Co.*., 3 F.3d 713, 719 (4th Cir. 1993). The Court listed opinions addressing "hostility to the Act." As the Court said in *Freeman-United Coal Mining Co. v. Office of Workers' Compensation*:

> Physicians retained by coal companies add that [coal workers' pneumoconiosis] is a restrictive lung disease, that is, it impedes breathing in, rather than an obstructive one, such as emphysema, that makes it difficult to breath out . . . Not all physicians agree, however, that coal workers' pneumoconiosis is always restrictive rather than obstructive or even that it always produces x-ray abnormalities. Whoever is right, the black lung statute has been interpreted to define coal workers' pneumoconiosis in accordance with the second, the broader, view, as any chronic lung disease caused in whole or in part by exposure to coal dust. So, if in an attempted rebuttal of the statutory presumption of pneumoconiosis the coal company tendered a doctor's report which merely stated that the miner has no signs of clinical pneumoconiosis (as that doctor understood the term), without commenting on the possibility that he might have another chronic lung disease caused or exacerbated by inhaling coal dust, the rebuttal would indeed fail.

Freeman-United Coal Mining Co. v. Office of Workers' Compensation Programs, 957 F.2d 302 (7th Cir. 1992) at 303.[15]

In *Stiltner v. Island Creek Coal* Co., 86 F.3d 337, 20 B.L.R. 2-246 (4th Cir. 1996), the Court held that a physician's opinion should not be discredited if he merely states that a miner "likely" would have exhibited a restrictive impairment in addition to chronic obstructive pulmonary disease. I find that Dr. Dahhan bases his conclusions on the premise that impairments from coal dust exposure are manifested by restrictive impairments. Dr. Dahhan does not state, as in *Stiltner*, that CWP "likely" causes restrictive impairment. Therefore, I afford Dr. Dahhan's opinions less weight because his interpretations are antithetical to the Black Lung benefits Act.

Judge Stewart afforded Dr. Fino's opinion limited weight because his opinion was contrary to the Act. Dr. Fino stated in his March 11, 1993 letter, "there is no contribution by coal mine dust

---

[15] *See also, Lane v. Union Carbide Corp.*, 105 F.3d 166 (4th Cir. 1997), where the court determined that a physician's opinion was not "hostile- to-the-Act" when he concluded that simple pneumoconiosis would "not be expected" to cause a pulmonary impairment. In so holding, the court concluded that this opinion was based upon the specific facts of the case unlike the opinion at issue in *Thorn v. Itmann Coal Co.*, 3 F.3d 713 (4th Cir. 1995), where the doctor stated that "simple pneumoconiosis" does not cause total disability "as a rule."

inhalation to chronic obstructive pulmonary disease."[16] Judge Stewart found Dr. Fino's premise that obstructive disorders cannot be caused by coal-mine employment was rejected in *Warth v. Southern Ohio Coal Co.*, 60 D.3d 173, 174 (4th Cir. 1995). I afford Dr. Fino's opinion less weight for the same reasons I discredited Dr. Dahhan's opinions.

I afford the most weight to Dr. Robinette who was claimant's treating physician since 1991. As such, generally his opinion would ordinarily be entitled to more weight. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989).[17] Dr. Robinette first treated claimant in 1985 and has been treating claimant every six months since 1991 and has observed his changing condition over an extended period of time. Furthermore, Dr. Robinette is well-qualified, Board-certified in internal medicine with a subspecialty in pulmonary diseases and a B-reader.

Although I found the x-ray evidence did not establish the existence of medical pneumoconiosis, Dr. Robinette's consistent observations of crackles, wheezes, diminished breath sounds and diagnosis of COPD, emphysema and bronchitis are sufficient to establish the existence of "legal" CWP under the Act. Dr. Robinette has consistently considered claimant's smoking history, finding in excess of 40 pack-years. Considering claimant's smoking history and 38 years of coal mine employment, Dr. Robinette found coal dust exposure significantly contributed to his respiratory symptoms. Dr. Robinette found coal dust exposure caused claimant's restrictive and part of his chronic airflow obstruction. Dr. Robinette was unable to separate the amount of damage caused by cigarette smoking as compared to the damage caused by coal dust exposure. Dr. Robinette is not required to assign an amount to the damage caused by coal dust exposure.[18] Considering that claimant smoked for approximately the same number of years he worked in the coal mines, that claimant has obstructive and restrictive ventilatory defects and numerous respiratory problems, I find Dr. Robinette's opinions the most consistent with claimant's smoking history, coal mine employment history, physical findings, and pulmonary function

---

[16] In his December 2, 1991 report, Dr. Fino also expressed an opinion which is of concern. Dr. Fino stated, "Elevated lung volumes on the most recent evaluation are also consistent with obstruction and would not be expected in a true restrictive defect due to pulmonary fibrosis as a result of pneumoconiosis." However, I do not find this opinion a per se hostile to the Act.

[17] *But see, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.2d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989). In *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). The Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents.

[18] In order to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather must prove by a preponderance of the evidence that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, *914 F.2d 35* (CA4 1990). (Affirms BRB's decision, in *Scott v. Mason Coal Co.*, No. 88-1838 BLA (BRB June 22, 1990)).

studies.

Dr. Robinette's diagnosis of COPD is supported by the various medical reports of record. Although all of the physicians may not have rendered an opinion on the cause of COPD, the doctors, in fact, found claimant suffered from COPD as early as 1984. In 1984, Dr. Turner diagnosed early CWP and COPD. However, Dr. Turner did not explain if claimant's COPD was due to coal dust exposure or cigarette smoking. Also in 1984, Dr. Gregoriou diagnosed COPD and CWP. However, Dr. Gregoriou did not offer any analysis as to the cause of claimant's diseases. In his 1984 report, Dr. Canaille, diagnosed chronic bronchitis, emphysema, and CWP, which he found "probably" related to coal dust exposure. In February of 1985, Dr. Smiddy also diagnosed COPD and stated he "believed" pneumoconiosis was a contributing factor. Dr. Steinberg was unable to render an opinion on whether claimant had CWP because he is not qualified as a B-reader. Dr. Steinberg found claimant suffered from COPD, and he assumed coal dust exposure contributed to claimant's COPD. Although Drs. Turner, Gregoriou, Smiddy, Steinberg and Dr. Kanwals' opinions on the cause of claimant's respiratory problems do not explain the etiology of claimant's COPD or are equivocal, the opinions confirm the diagnoses of COPD as early as 1984. I limit the weight of these opinions to supporting the diagnosis of COPD and other pulmonary diseases.

Dr. Branscomb opined that claimant does not have CWP and identified an obstructive defect and a minimal restrictive component. I do not find Dr. Branscomb's opinion well reasoned. Dr. Branscomb asserts the x-rays and medical records do not support a diagnosis of CWP. However, he does not offer a determinative explanation of the cause of claimant's impairment. Dr. Branscomb equivocally stated that claimant's elevated hemidiaphragm could reduce claimant's lung capacity. Dr. Branscomb was also unable to determine whether claimant's impairment was sufficient to prevent him from performing his last coal mine job. Therefore, I find Dr. Branscomb's opinion not well-reasoned and give it little weight.

Dr. Byers found claimant suffered from a combined obstructive and restrictive pulmonary disease. Dr. Byers explained that none of claimant's restrictive lung disease are related to CWP because he found no evidence to document CWP, citing negative chest x-ray interpretations. Dr. Byers attributed claimant's problems to asthma, and tobacco abuse. I do not afford Dr. Byers

opinion much weight because he does not sufficiently explain the effect that 38 years of coal mine employment and coal dust exposure had on claimant's asthma and other pulmonary problems.

In 1985, Dr. Dahhan observed scattered expiratory wheezing and diagnosed chronic bronchitis due to cigarette smoking. In his October 21, 1991 report, Dr. Dahhan opined that claimant's 40 years of cigarette smoking had caused severe COPD and that claimant is not able to continue his previous coal mine employment. During his deposition testimony, Dr. Dahhan opined that claimant's pulmonary function studies and examination were most consistent with emphysema, which he found "most likely"

caused by cigarette smoking. As discussed above, I afforded Dr. Dahhan's opinion on the cause of claimant's pulmonary disease less weight because he opined that coal dust exposure is manifested by restrictive lung disease. Furthermore, Dr. Dahhan' opinion on the cause of claimant's COPD and emphysema is equivocal. However, Dr. Dahhan's diagnoses of COPD and emphysema are consistent with Dr. Robinette's findings.

Dr. Fino also found a disabling respiratory impairment and obstructive impairment which he attributed to smoking. As discussed above, I afforded Dr. Fino's opinion on the cause of claimant's impairment less weight. However, Dr. Fino's findings of a disabling respiratory impairment support Dr. Robinette's conclusions.

In September of 1984, Dr. Sargent diagnosed moderate hypoxemia, hypercarbia, mixed restrictive and obstructive ventilatory impairment secondary to both cigarettes and "probably" CWP. However, after evaluating claimant on two occasions, Dr. Sargent stated, in a letter dated January 28, 1985, that it was his impression that claimant suffered from a mixed ventilatory impairment both obstructive and restrictive in nature due to obstructive lung disease from smoking cigarettes and restrictive lung disease secondary to CWP.[19] Although Dr. Sargent was not certain of whether CWP contributed to claimant's ventilatory impairment in September of 1984, after a subsequent examination, Dr. Sargent found claimant's lung disease due to both cigarettes smoking and CWP. Therefore, I find Dr. Sargent's opinion probative on the cause of claimant's lung disease.

Dr. Hippensteel found no evidence of CWP and based his conclusion, in part, on the majority of negative x-ray interpretations. After noting a pulmonary function study showed severe restriction, Dr. Hippensteel then opined that claimant had significant obstructive pulmonary dysfunction aggravated by obesity and decreased function of the left diaphragm. Dr. Hippensteel opined that claimant's elevated diaphragm and atelectasis are causing his lungs not to participate in diffusion and causing his respiratory impairment. I do not find Dr. Hippensteel's opinions persuasive. Although he found the pulmonary functions studies did not rule out an obstruction, Dr. Hippensteel does not diagnose COPD, which the majority of physicians diagnosed. Dr. Hippensteel attributes claimant's pulmonary problems to an elevated diaphragm and atelectasis. The majority of physicians found claimant's pulmonary problems related to COPD. Furthermore, I find Dr. Robinette's opinion more persuasive. Dr. Robinette explained that claimant's elevated hemidiaphragm could affect lung function, but does not account for the progressive volume loss Dr. Robinette has observed over the years. Therefore, I do not afford Dr. Hippensteel's opinion great weight.

Crediting Dr. Robinette's observations over an extended period of time in conjunction with the majority of physicians diagnosing COPD and Dr. Sargent's opinion, I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich*

---

[19] In Judge Stewart's April 21, 1998 opinion, the date of Dr. Sargent's letter is listed as January 28, 1995. This is a typographical error. The letter is dated January 28, 1985.

Collieries, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994).

C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. As discussed above, I credited Dr. Robinette's opinion that claimant's COPD was caused, in part, by coal dust exposure.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(c)(1) through (c)(5) set forth criteria to establish total disability: (1) pulmonary function studies with qualifying values; (2) blood gas studies with qualifying values; (3) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and (5) lay testimony.[20] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of

total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP,[Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v.*

[20] 20 C.F.R. § 718.204(c). In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

Street, 42 F.3d 241, 243 (4th Cir. 1994), the Court "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.'" Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id*. at 534.

Section 718.204(c)(3) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure.[21] § 718.204(c)(5) is not applicable because it only applies to a survivor's claim in the absence of medical evidence.

Section 718.204(c)(1) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). Seven pulmonary function studies were performed between October 22, 1985 and April 11, 2000. All of the studies produced qualifying results pre-bronchodilator. The July 10, 1991 and the April 9, 1997 studies did not produce qualifying results post-bronchodilator. However, subsequent studies on April 1, 1998 and April 11, 2000, produced qualifying results post-bronchodilator. Based on the majority of qualifying results and the most recent studies producing qualifying results, I find claimant has established total disability pursuant to § 718.204(c)(1).

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(c)(2). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). Nine arterial blood gas studies were performed between October 22, 1985 and April 9, 1997. Although some of the physicians diagnosed mild hypoxemia and hypercarpnia, none of the tests produced qualifying results. Therefore, I find the claimant has failed to establish total disability under § 718.204(c)(2).

Finally, total disability may be demonstrated, under § 718.204(c)(1), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional

[21] Although cor pulmonale is mentioned in a few medical records, none of the physicians diagnosed the condition or explained the rationale. Therefore, I find insufficient evidence to sustain a diagnosis of cor pulmonale.

requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I find claimant has established that he is totally disabled under § 718.204(c)(1), based on physicians' reports. The majority of physicians are in agreement that claimant has a disabling pulmonary and respiratory impairment. The physicians disagree on the cause of claimant's impairment. In September of 1984, Dr. Sargent found claimant completely disabled by a severe ventilatory impairment. Drs. Smiddy, Gregoriou, Byers, Robinette, Fino, and Steinberg found claimant totally disabled due to a respiratory impairment. Although Dr. Dahhan did not find claimant totally disabled in 1985, he subsequently found, in October of 1991, that claimant had a respiratory disability and did not have the capacity to continue his previous coal mining employment. Dr. Hippensteel found claimant's lung disease sufficient to prevent him from working at his previous coal mine employment.

Drs. Turner and Kanwal did not render an opinion on total disability. Dr. Branscomb was unable to determine whether claimant's impairment was sufficient to prevent him from performing his last coal mine job.

I find that the miner's last coal mining positions required mild to moderate manual labor. Claimant was required to stoop, walk distances, and occasionally shovel. Because the claimant's symptoms render him unable to walk short distances, climb and stoop, I find he is incapable of performing his prior coal mine employment.

Based on qualifying pulmonary function studies and a majority of medical reports finding claimant totally disabled, I find the claimant has not met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994).

E. Cause of total disability

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[22] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir.

[22] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, *914 F.2d 35* (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director,*

1995); *Jewel Smokeless Coal Corp. v. Street,* 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street,* 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.*.(So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability). The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion, may make his opinion "unreasoned." *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

Where an Administrative Law Judge determines that a miner suffers from pneumoconiosis, a medical opinion finding the miner does not suffer from the disease "can carry little weight" in assessing the etiology of the miner's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 116 (4th Cir. 1995).[23] *Grigg v. Director, OWCP,* 28 F.3d 416, 419 (4th Cir. 1994). If a physician finds no respiratory or pulmonary impairment based on an erroneous diagnosis that the miner does not suffer from pneumoconiosis, her opinion is "not worth of much, if any, weight." *Citing Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993).[24]

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R.

OWCP, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

[23] The Court noted that the Administrative Law Judge may credit such an opinion if there are "specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon her disagreement with the Administrative Law Judge's findings as to either or both of the predicates [pneumoconiosis and total disability] in the causal chain." *Toler*, 43 F.3d at 116.

[24] These opinions have been limited by *Dehue Coal Co. v. Ballard*, 65 F.3d 1189 (4th Cir. 1995), where the Court noted *Grigg* involved rebuttal of the interim presumption of total disability found in Part 727.203(a)(1), based on x-ray evidence. *See also, Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995)(*Hobbs II*). A physician's opinion that a claimant is not impaired by CWP does not necessarily conflict with a judge's legal conclusion that the claimant suffers from CWP and may have probative value. This is so because the legal definition of CWP is much broader than the medical definition.

1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990). Although Dr. Robinette was not able to assign a percentage to the amount cigarette smoking and coal dust exposure which contributed to his disability, Dr. Robinette found occupational lung disease significantly contributed to his respiratory symptoms.

As stated above, I found the pulmonary function studies established total disability and that a majority of the medical reports established claimant has a totally disabling pulmonary or respiratory impairment due to COPD. The physicians disagreed on the cause of claimant's pulmonary problems. However, as discussed above, I found Dr. Robinette's opinion the most persuasive. Dr. Robinette found claimant had CWP and COPD, which was caused, in part by coal dust exposure. Dr. Robinette opined that claimant was totally disabled due to his lung disease and that occupational lung disease significantly contributed to his respiratory symptoms. Therefore, I find that pneumoconiosis is a contributing cause of claimant's total disability.

F. Date of entitlement

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis. 20 C.F.R. § 725.503. He is entitled to benefits as of August 1, 1991, the date of claimant's modification application because no specific onset date of disability is evident from the record. 20 C.F.R. § 725.503(b).

ATTORNEY FEES

An application by the claimant's attorney for approval of a fee has not been received; therefore no award of attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365- 725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has established a mistake of fact and has now demonstrated elements of entitlement which were previously adjudicated against him. The claimant has

pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis arose out of his coal mine employment. The claimant is totally disabled. His total disability is due to pneumoconiosis. He is therefore entitled to benefits.

ORDER

It is ordered that the claim of JOHNNY B. TURNER for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, CLINCHFIELD COAL COMPANY, shall pay to the claimant all benefits to which he is entitled under the Act commencing August 1, 1991.[25]

RICHARD A. MORGAN
Administrative Law Judge

RAM:EAS:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[25] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund with interest for the full amount of all such payments. 20 C.F.R. § 725.602(a).

If an employer does not pay benefits after the Director's initial determination of eligibility, it may be ordered to pay the beneficiary simple interest on all past due benefits at a rate according to the Internal Revenue Code § 6621. 20 C.F.R. §§ 725.608(a) and 725.608(c).